ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

BEHAVIORAL HEALTH SERVICES PROVIDER QUALIFICATION FORM FOR LCSW, LMFT AND LPC

Name:_____ Telephone number:_____
FAX number:_____

Contact Person: _____
Address: _____
_____
_____

Description of outpatient mental health services provided for children:

_____
_____
_____
_____
_____

Business Hours:

_____

Description of how and by whom children's services are covered 24 hours/7 days a week, addressing crisis services as well as routine services delivery:

_____
_____
_____
_____
_____
_____

Do you provide medication management through your facility?

_____

If not, how is medication management handled for your clients?

_____
_____
_____
_____

Description of how you will collaborate with other agencies/individuals to facilitate quality and continuity of care:

_____
_____
_____
_____

Please attach the following items:

1. Names, credentials and relevant experience of backup and medication management physicians.
2. Names, credentials and relevant experience of staff providing children's mental health services.
3. Copies of any affiliation agreements with other agencies/professionals that provide mental health services for your clients.
4. Copies of pertinent certifications and/or licenses, i.e. JCAHO, CARF, staff licensure or certification by State boards to practice mental health services, etc.
5. Provide copies of any forms used for documentation (treatment plan, psychosocial history, etc.)

Please return form to mailing address below or FAX to (501) 686-9182.

Provider Qualifications
Division of Behavioral Health Services
305 South Palm Street
Little Rock, Arkansas 72205

Physical Address:
4800 West 7th Street
Little Rock, Arkansas